GASTROENTEROLOGY WAIVERS

CONDITION: REFLUX ESOPHAGITIS (GERD) AND HIATAL HERNIA (ICD9 530.1 & 553.3) Revised November 2002

AEROMEDICAL CONCERNS: Retrosternal pain associated with either GERD or Hiatal Hernia (HH) can be a significant distracter in the aviation environment. Acid regurgitation can lead to attacks of bronchoconstriction in susceptible individuals. Exposure to -Gz may exacerbate the symptoms of both GERD and HH.

WAIVERS:

1. Initial Applicants:

a. Class 1A/1W: Exception to policy for initial flight applicants are only required for cases of GERD or symptomatic HH demonstrating one or more of the five warning symptoms: dysphagia or odynophagia, symptoms persisting or progressive on chronic therapy, bleeding or iron deficiency, unexplained weight loss, or extraesophageal symptoms (e.g. cough, choking, chest pain, asthma). GERD or HH which is asymptomatic or minimally symptomatic requiring chronic therapy or occasional treatment with the medications listed below to include over the counter H2 Blockers will be listed as Information Only.

b. Class 2, 3, 4: Waivers are only required for cases of GERD or symptomatic HH demonstrating one or more of the five warning symptoms as listed above. GERD or HH which is asymptomatic or minimally symptomatic requiring chronic therapy or occasional treatment with the medications listed below to include over the counter H2 Blockers will be listed as Information Only.

2. Rated Aviation Personnel (All Classes): Waivers are only required for cases of GERD or symptomatic HH demonstrating one or more of the five warning symptoms as listed above. GERD or HH which is asymptomatic or minimally symptomatic requiring chronic therapy or occasional treatment with the medications listed below to include over the counter H2 Blockers will be listed as Information Only.

ICD9 Code	Condition
530.1	Reflux esophagitis
530.3	Esophageal stricture
530.7	Mallory-Weiss Tear
553.3	Hiatal Hernia

INFORMATION REQUIRED:

1. Symptoms of uncomplicated GERD may undergo an initial trial of empiric therapy without endoscopic evaluation as long as symptom relief along with medication regimen are documented in the annual FDME.

2. Complicated (involving any of the five warning signs listed in paragraph 4.a-e.) symptomatic GERD or HH requires submission of endoscopy to exclude gastric or duodenal ulceration and malignancy.

3. Cultures for H. pylori may be indicated depending on endoscopic findings.

4. Aeromedical summary must include documentation regarding the presence or absence of the following five warning symptoms:

a. Dysphagia or odynophagia.

b. Symptoms that are persistent or progressive on therapy.

c. Bleeding or iron deficiency.

d. Unexplained weight loss.

e. Extraesophageal symptoms (e.g. cough, choking, chest pain, asthma).

FOLLOW-UP: Follow-up examination by an internal medicine or gastroenterology specialist is only required if there is evidence of progressive disease, poor maintenance control, or recurrent symptomatology.

TREATMENT: Individuals with typical gastroesophageal reflux symptoms should initially be managed by lifestyle modifications. Often, control of mild symptoms may be achieved through conservative mechanisms. These include weight loss, elevating the head of the bed, judicious use of antacids, restriction of alcohol use, elimination of smoking, avoidance of meals before bedtime, avoidance of carminatives, and avoidance of tight fitting clothing. Refractory disease may require surgery for cure. Surgical repair of HH is compatible with return to full flight status, no wavier required, provided the repair is without complication and 60 days have elapsed since surgery.

The following medications may be used and waiver recommended once the treated patient demonstrates no idiosyncratic reactions to the medication and the medication is effective in providing relief of symptoms.

GI MEDICATIONS: All antacids (chronic use) and medications listed below are Class 3, except as noted. No additional requirements for a waiver other than the complete evaluation of the underlying condition and documentation of medication efficacy.

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1. **Antacids:** Chronic use is Class 3. Occasional or infrequent use is Class 1. Check electrolytes when used chronically.

2. **H2 Blockers (CIMETIDINE (Tagamet), RANITIDINE (Zantac), FAMOTIDINE (Pepcid), NIZATIDINE (Axid))**: Occasional drowsiness is associated with these medications. When treatment is first initiated, a 72-hour observation (while the aviator has Duties Not Including Flying (DNIF)) is required to ensure the absence of any significant side effect.

3. **Proton Pump Inhibitor:** Omeprazole (Prilosec), Lansoprazole (Prevacid), Pantoprazole (Protonix), Rabeprazole (Aciphex), and Esomeprazole (Nexium).

4. **Sucralfate (Carafate):** Class 2A, provided underlying condition does not require waiver.

DISCUSSION: GERD is a chronic, relapsing condition with associated morbidity and mortality and an adverse impact on quality of life. The disease is common with an estimated lifetime prevalence of 25-35 percent in the U.S. population. GERD can usually be diagnosed on clinical presentation alone. As many as 10 percent of Americans have episodes of heartburn daily and 44 percent have symptoms at least once a month. Classic symptoms include heartburn (pyrosis) and regurgitation. Most patients gain adequate symptom control and esophageal healing through a combination of lifestyle modifications and drug therapy and do not require surgery. Lifestyle modification and antacids provide relief in 20 percent of patients. H2 Blockers should be used and dosage maximized prior to PPI use. PPI should be used in the event of treatment failure with H2 blockers and in those with erosive esophagitis by endoscopy.

Esophageal reflux is experienced by 10 percent of Americans at some time and, with careful scrutiny, HH can be demonstrated in most people over the age of 40. The majority of these cases are asymptomatic, but 15 percent of cases will have frequent symptoms of reflux. The major complications of esophagitis are stricture formation (8-20 percent), Barrett's epithelium (8-20 percent), and hemorrhage (less than 2 percent). Mortality associated with esophagitis is minimal with estimates of 0.1:100,000. Recovery from surgery for HH will depend on whether an abdominal, thoracic, or laproscopic (most common) approach was used. In esophagitis, 90 percent of patients lose their symptoms on reaching their recommended weight.

REFERENCE: Scott M, and Gelhot A. *Gastroesophageal Reflux Disease: Diagnosis and Management*. American Family Physician 1999. 59:5.